

806 KAR 12:092. Unfair life and health insurance claims settlement practices.

RELATES TO: KRS 304.2-165, 304.3-200, 304.3-210, 304.12-010, 304.12-220, 304.12-230, 304.12-235, 304.29-341, 304.32-270, 304.38-200, 342.325

STATUTORY AUTHORITY: KRS 304.2-110, 304.32-250, 304.38-150

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110 provides that the Executive Director of Insurance may make reasonable regulations necessary for or as an aid to the effectuation of any provision of the Kentucky insurance code. KRS 304.32-250 provides that the executive director may promulgate reasonable administrative regulations which he deems necessary for the proper administration of KRS 304.32. KRS 304.38-150 provides that the Executive Director of Insurance may promulgate reasonable administrative regulations which he deems necessary for the proper administration of KRS 304.38. This administrative regulation defines unfair life and health insurance claims settlement practices.

Section 1. Definitions. As used in this administrative regulation:

- (1) "Agent" means any person authorized to represent an insurer with respect to a claim;
- (2) "Beneficiary" means, for the purpose of life and health insurance, the party entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured;
- (3) "Claimant" means an insured, the beneficiary, or legal representative (e.g., administrator, executor, guardian, or similar person) of the insured, including a member of the insured's immediate family designated by the insured (the insurer may require written proof of the designation), making the claim under a policy;
- (4) "Claim file" shall mean any retrievable electronic file, paper file, or combination of both;
- (5) "Executive Director" means the executive director of the Kentucky Office of Insurance;
- (6) "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and, explanation of benefits forms relative to the claim;
- (7) "Good faith" means an honest intention to abstain from taking any unconscientious advantage of another, together with absence of all information, notice, or benefit or belief of facts which render a transaction unconscientious;
- (8) "Insured" means, for the purpose of life or health insurance, the party named on a policy, certificate, or contract as the individual with legal rights to the benefits provided by the policy, certificate, or contract;
- (9) "Insurer" means any insurer, fraternal benefit society, nonprofit hospital, medical, surgical, dental, and health service corporations and prepaid dental plan organization, including agents and third party administrators;
- (10) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by a policy, certificate or contract;
- (11) "Notification of claim" means a notice to the insurer that a loss has occurred or is about to be incurred;
- (12) "Policy", "certificate" or "contract" include any contract of an insurer providing indemnity or other coverage for medical, health or hospital goods and services, but do not include contracts of workers' compensation;
- (13) "Proof of loss" means written proofs, such as claim forms, medical bills, medical authorizations, or other reasonable evidence of the claim that is ordinarily required of all insureds or beneficiaries submitting the claims;
- (14) "Reasonable explanation" means that sufficient information shall be included in the explanation of benefits as to enable the insured or beneficiary to compare the allowable benefits with policy provisions and determine whether proper payment has been made;
- (15) Delay or denial of a claim is "without reasonable foundation" when there is no rational rela-

tionship between the reasons for the delay or denial of a claim and the policy, certificate, or contract, applicable law, or applicable facts;

(16) "Written communications" include all correspondence, regardless of source or type, that is materially related to the handling of the claim.

Section 2. Scope and Purpose of this Administrative Regulation. (1) This administrative regulation sets forth minimum standards for the investigation and disposition of life and health insurance claims arising under policies, certificates, and contracts. It is not intended to cover claims involving workers' compensation insurance since all questions arising under KRS Chapter 342 shall be resolved by workers' compensation administrative law judges. This administrative regulation is intended to define procedures and practices which constitute unfair claims settlement practices.

(2) The National Association of Insurance Commissioners, which created the model regulation on which this administrative regulation is based, has stated that its model regulation is not appropriate for a state which allows a private cause of action. Accordingly, the sole purpose of this administrative regulation is to provide guidance to the commissioner and his designees in their investigations, examinations, and administrative adjudication and appeals therefrom.

Section 3. Claim Practices. (1) Every insurer, upon receiving due notification of a claim shall, within fifteen (15) calendar days of the notification, provide necessary claim forms, instructions, and reasonable assistance so the insured can properly comply with insurer requirements for the filing of a claim.

(2) Upon receipt of proof of loss from a claimant, the insurer shall begin any necessary investigation of the claim within fifteen (15) calendar days.

(3) The insurer's standards for claims processing shall require that notice of claim or proofs of loss submitted against one (1) policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability.

(4) The insurer shall affirm or deny any liability on claims within a reasonable time and shall offer payment within thirty (30) calendar days of receipt of due proof of loss. If the insurer fails to pay the claim within thirty (30) days of receipt of due proof of loss, and the delay or denial is due to lack of a good faith attempt to settle the claim, the claim bears interest at the rate of twelve (12) percent per annum from the expiration of thirty (30) days from the receipt of due proof of loss. If the delay or denial is without reasonable foundation, the insured shall be reimbursed for reasonable attorney's fees incurred in collecting the claim. If a portion or portions of the claim are in dispute, the insurer shall tender payment for any portion or portions of the claim which are not in dispute within thirty (30) days of receipt of due proof of loss.

(5) With each claim payment, the insurer shall provide to the insured an explanation of benefits which shall include the name of the provider of health care services covered, dates of service, and a reasonable explanation of the computation of benefits.

(6) An insurer shall not impose a penalty on any insured for noncompliance with insurer requirements for precertification unless the penalties are specifically and clearly set forth in writing in the policy.

(7) If a claim remains unresolved for thirty (30) days from the receipt of due proof of loss, the insurer shall provide the insured or, when applicable, the insured's beneficiary, with a reasonable written explanation of the delay. In credit, mortgage, and assigned health insurance claims, the notice

shall also be provided to the debtor who is the insured or health care provider in addition to the insured. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the date of initial notification and every forty-five (45) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for the investigation. The notice shall also describe to the insured the availability of interest and attorney's fees specified in subsection (4) of this section.

(8) The insurer shall acknowledge and respond within fifteen (15) calendar days to any written communications relating to a claim.

(9) When a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) calendar days of the determination. The notice shall refer to the policy provision, condition, or exclusion upon which the denial is based.

(10) Insurers shall not deny a claim based on information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

(11) Insurers shall not refuse to settle claims on the basis that responsibility for payment should be assumed by others except as provided by policy, certificate, or contract provisions.

(12) All insurers offering cash settlements of first party long term disability income claims (except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability) shall develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies such as mortality, morbidity, and interest rate assumptions, and other facts appropriate to the risk. A copy of the amount so calculated shall be given to the insured and signed by the insured at the time a settlement is entered into.

(13) No insurer shall indicate to a first party claimant on a payment draft, check, or in any accompanying letter that the payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the contract.

(14) Insurers shall not withhold any portion of any benefit payable as a result of a claim on the basis that the settlement held is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless:

(a) The insurer has within its files clear, documented evidence of an overpayment and written authorization from the insured permitting the withholding procedure; or

(b) The insurer has within its files clear, documented evidence of the following:

1. The overpayment was clearly erroneous under the provisions of the policy. If the overpayment is the subject of a reasonable dispute as to facts, the procedure specified in this paragraph shall not be used;

2. The error which resulted in the payment is not a mistake of the law;

3. The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date that clear, documented evidence of discovery of such error is included in its file. For the purpose of this subparagraph, the date of the error shall be the day on which the draft, check, or other claim payment is issued; and

4. The notice states clearly the nature of the error and states the amount of the overpayment.

(15) Insurers shall not continue negotiations with a claimant who has no legal representation until the claimant's rights may be affected by a statute of limitations or a time limitation in a policy, certificate, or contract without giving the claimant written notice that the time limitation may be expiring. The notice shall be mailed or delivered to the claimant at least thirty (30) days prior to the date on which the time limit may expire.

Section 4. File and Record Documentation. Each insurer's claim files are subject to examination by the executive director or the executive director's designees. To aid in an examination:

(1) The insurer shall maintain claim data that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, and date of denial or date closed without payment. This data shall be available for all open and closed files for the current year and the five (5) preceding years.

(2) Documentation shall be contained in each claim file to permit reconstruction of the insurer's activities relative to each claim.

(3) Each document within the claim file shall be noted as to date received, date processed, or date mailed.

(4) For those insurers which do not maintain hard copy files, claim files shall be accessible from a computer terminal available to examiners or micrographics and be capable of duplication to hard copy.

Section 5. Severability. If any provision of this administrative regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected thereby.

Section 6. Effective Date. This administrative regulation shall become effective upon completion of its review pursuant to KRS Chapter 13A. (17 Ky.R. 806; Am. 1503; eff. 11-15-90; TAm eff. 8-9-2007; TAm eff. 10-9-2008.)